KAISER PERMANENTE®

California Service Center
P.O. Box 23219
San Diego, CA 92193-3219

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Rene Apelo
140 MIRROR CT
PATTERSON, CA 95363-8304

Purchaser/EU: 887/11
Purchaser Name: CITY OF SAN JOSE
Subscriber MRN: 11-0012139657
Dependent Name: Renee Apelo
Dependent MRN: 11-12139661

Case Number: STN_000024620832

000832 1/4

January 21, 2021

Dear Rene Apelo,

This letter is to inform you that Renee Apelo has been approved to receive Disabled Dependent status under your health plan coverage. **Now that your dependent has been certified, it is necessary for you to contact your employer with a copy of this letter showing that your dependent has been approved with Disabled Dependent status. Your employer will then follow the group contract rules to determine your dependent's eligibility and effective date of enrollment.**

Permanent status as a Disabled Dependent is effective as of 01/01/2021.

Health Plan will not require proof more frequently than the two period following your dependent's attainment of Disabled Dependent status as specified in your health plan contract. We will notify you of this request when appropriate.

If you have any questions regarding this letter, please call **1-800-731-4661**. TTY users should call **711**.

Thank you for choosing Kaiser Permanente.

Sincerely,

Dependent Certification Team

NCR

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Member Services Department return to:
Kaiser Foundation Health Plan, Inc.
P.O. Box 23219
San Diego, California 92193-3219
Or fax to: 1-855-355-5334
Questions: 800-731-4661

Continued Coverage for Overage Dependent Application

PART A - TO BE COMPLETED BY SUBSCRIBER/PLAN PARTICIPANT

It is important to complete the application in full. Please print or type in blue or black ink.
Incomplete or omitted information may result in the application being delayed or returned without processing.

SUBSCRIBER INFORMATION

SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL)	KP MEDICAL RECORD NUMBER	GROUP NUMBER
Rene Apelo	11-12139657	887

ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)
140 MIRROR CT, PATTERSON, CA, 95363

PHONE NUMBER	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER
(408) 564-9926	414-83-4014	CITY OF SAN JOSE

DEPENDENT INFORMATION

DEPENDENT NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH (MONTH-DATE-YEAR)	KP MEDICAL RECORD NUMBER
Renee Apelo	01/18/1997	11-12139661

ADDRESS – IF DIFFERENT FROM SUBSCRIBER ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)

PHONE NUMBER	SOCIAL SECURITY NUMBER	411-89-1646

VERIFICATION AND ATTESTATION OF ELIGIBILITY FOR CONTINUED COVERAGE FOR OVERAGE DEPENDENT

IS THE DEPENDENT CURRENTLY ENROLLED IN YOUR HEALTH PLAN? ☑ YES ☐ NO

DOES THE SUBSCRIBER CONTRIBUTE 50% OR MORE TO THE DEPENDENT'S MONTHLY EXPENSES? ☑ YES ☐ NO

IS THE DEPENDENT CURRENTLY EMPLOYED? ☐ YES ☑ NO

IS THE DEPENDENT CAPABLE OF SELF-SUSTAINING EMPLOYMENT? ☐ YES ☑ NO

IS THE DEPENDENT RECEIVING SOCIAL SECURITY INCOME? ☑ YES ☐ NO

The information that has been provided above is true and accurate to the best of my knowledge and belief:

X _____ RENE APELO 12/18/2020

SIGNATURE OF SUBSCRIBER | PRINT NAME | DATE

AUTHORIZATION FOR REPRESENTATIVE

This authorization identifies the subscriber as the dependent's representative for purposes of Kaiser Permanente's review of the dependent's eligibility for continuing coverage under the subscriber's health plan as an overage dependent.

I authorize Kaiser Foundation Health Plan, Inc ("Kaiser Permanente") to disclose Protected Health Information regarding my medical condition and care, eligibility, and/or payment information to the subscriber identified on this form. The information disclosed must be relevant to the eligibility review being processed by the Dependent Certification Team as of 12/18/2020 (date of application request).

DEPENDENT SIGNATURE: Renee Apelo DATE: 1/12/2021

(If the dependent cannot or is unable to write, the subscriber may indicate "Cannot write" above)

SUBSCRIBER SIGNATURE: _____ DATE: 12/18/2020

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Continued Coverage for Overage Dependent Application

PART B - TO BE COMPLETED BY LICENSED MEDICAL DOCTOR

It is important to complete the application in full. Please print or type in blue or black ink.

Instructions for the dependent's physician: The following information is needed to help determine eligibility for continued coverage for an overage dependent under their parent's health plan. To be eligible for this continued coverage, the dependent must be incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition.

- Please describe the nature and severity of the dependent's mental or physical impairment in as much detail as possible.
- You may fax or mail this form directly to Kaiser Permanente, or you may return the completed application to the subscriber to remit.

DEPENDENT/PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	KP MEDICAL RECORD #
Renee Apelo	11-12139661
SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL)	KP MEDICAL RECORD #
Rene Apelo	11-12139657

PHYSICIAN TO COMPLETE THE FOLLOWING:

DESCRIPTION OF ANY LIMITATIONS OF PATIENT'S CONDITION DUE TO DIAGNOSIS:
Autistic Disorder

DATE DISABILITY OCCURRED OR DATE OF ONSET OF DISABILITY: (Month/Day/Year)
diagnosed in 2001 @ Berryessa Union School District

IN YOUR MEDICAL OPINION, IS THE DISABILITY A PHYSICALLY OR MENTALLY DISABLING INJURY, ILLNESS OR CONDITION?

YES ☒ NO ☐

Note: Including biological disability. In addition, disabling illness or condition means the disability significantly interferes with a major life function which would likely prevent self-sustaining employment.

IN YOUR MEDICAL OPINION, IS THIS DISABILITY TEMPORARY OR PERMANENT?

TEMPORARY ☐ PERMANENT ☒

IF THIS DISABILITY IS TEMPORARY, PLEASE PROVIDE AN EXPECTED DATE OF IMPROVEMENT / OR THE EXPECTED DATE OF RE-EVALUATION OF DISABILITY:

(Month/Day/Year)_____

IN YOUR MEDICAL OPINION, IS THE PATIENT CAPABLE OF BEING FINANCIALLY INDEPENDENT WITHOUT THE ASSITANCE OF THE SUBSCRIBER (PARENT)?

YES ☐ NO ☒

IN YOUR MEDICAL OPINION, IS THE PATIENT CAPABLE OF MAINTAINING FULL-TIME EMPLOYMENT?

YES ☐ NO ☒

PHYSICIAN'S SIGNATURE: Thao Pham	DATE: 1/7/2021
PRINT NAME: Thao Pham M.D.	KP FACILITY OR PHYSICIAN'S MAILING ADDRESS: (NUMBER, STREET, CITY, STATE AND ZIP CODE) KAISER PERMANENTE 770 EAST CALAVERAS BLVD. MILPITAS, CA 95035 (408) 945-2933
TELEPHONE NUMBER OR KP TIE LINE #:	

(MACF0001) Rev 01-2020